CONSENT FOR RELEASE OF MEDICAL RECORDS AND INFORMATION TO

LLNL Health Care Facilitator
7000 East Avenue, L-707
Livermore, CA 94550
ATTENTION: Johnetta Jones

AUTHORIZATION:

I hereby consent to and authorize _____
(***NAME OF AGENCY, PHYSICIAN, HOSPITAL OR FACILITY)***

_____
(ADDRESS OF AGENCY, PHYSICIAN, HOSPITAL OR FACILITY)

to furnish to an agent, designee or representative of the University of California, Lawrence Livermore National Lab. Benefits Office, medical records and information pertaining to medical history, services rendered or treatment given to:

_____ during _____
(NAME OF PATIENT OR CLIENT) ***(TIME PERIOD SERVICES WERE RECEIVED)***

for purposes of review and evaluation. This authorization is limited to the following medical records and types of information: nursing admission notes and assessment; daily nursing notes; physicians progress notes; physician orders; treatment record and profile; daily therapy documentation; social assessment; specialty evaluations; lab, radiology and pathology reports; case history; and inner facility transfer notes.

DURATION:

This authorization shall become effective immediately and shall remain in effect until resolution of this case by an administrative body, or for three (3) years.

RESTRICTIONS:

I understand that the requestor may not further use or release the medical information unless an authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY:

I understand that I have a right to receive a copy of this authorization upon my request. Copy requested and received: Yes ( ) No ( ) Initials: _____

A photocopy or facsimile copy of this authorization shall have the same effect as the original.

SIGNATURE:

Signed: _____ Date: _____
Print full name: _____ Date of Birth: _____
If signed by other than the patient, indicate relationship: _____

This release complies with the California Confidentiality of Medical Information Act, Cal. Civil Code § 56 et seq.